

**Office of Comprehensive Services
State Sponsored Utilization Review**

Initial Utilization Review

Client:
Social Security #:
CSA Locality:
Service Provider:
Reporting Period:
**Date of Most Recent CANS
Administration:**

DOB/Age:
CSA Contact Person:

Admission Date:
Review Date:

Case History and Reason for Placement:

Diagnosis (if available):

Psychological Evaluation Findings (if available):

Current Medications:

Services Utilized in the Past:

Client and Family Strengths:

Treatment Concerns/Challenges:

SERVICE PLAN REVIEW (includes Foster Care Plan, if applicable)

Include description and notes related to progress or lack of progress for each goal:

IFSP Goals/Objectives	Service Provider Goals/Objectives
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

**Is the local CSA case manger participating in Service Planning/Treatment Team meetings with the service provider?
If so, how?**

Is service provider participating in FAPT Meetings? If so, how?

Discharge Plan:

Contacts with Locality by UR Consultant:

Name:

Date:

Content:

Consults (Magellan, DBHDS professional) by UR Consultant:

Name:

Date:

Content:

Recommendations:

Utilization Review Consultant:

Next Review Date:

CC: CPMT Chair